

1/8
FOR STATE HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 208 Maryland Avenue | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 208 Maryland Avenue | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last LEROY E. ADAMS | | | | 4. DATE OF DEATH Month February Day 22 Year 1966 | | | | 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Feb. 6, 1910 9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Owner 10b. KIND OF BUSINESS OR INDUSTRY Gasoline & Oil 11. BIRTHPLACE (State or foreign country) Wingate, Dor. Co., Md. 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Edward Adams 14. MOTHER'S MAIDEN NAME Mamie Windsor | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Mrs. Thornie Phillips, Baltimore, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning DUE TO Conditions, if any, which gave rise to immediate cause (b) 9160 (c), stating the underlying cause last. DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Instant | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trapped in burning dwelling. | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 3:45 PM 2/22/66 20d. INJURY OCCURRED While <input type="checkbox"/> el work <input type="checkbox"/> Not While <input checked="" type="checkbox"/> el work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Cambridge (County) Dor. (State) Md. | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED 2/23/66 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Feb 26, 1966 22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park 22d. LOCATION (City, town, or county) Cambridge, Maryland | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland | | | | 24a. REC'D BY REGISTRAR MAR 1 1966 24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | |

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 6 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

VR A15ME
5M 1/63

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | | | | |
|---|------------------|---|--|---|--|--|--|---|--|---|------------------|------------------------------|------|--|-------|--|------|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 2 Weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution/ Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Creek d. STREET ADDRESS Md. Route 16 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Lula Middle Jones Last Banning | | | | 4. DATE OF DEATH Month February Day 17 , Year 1966 | | | | | | | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH Jan. 12, 1890 | | 9. AGE (In years last birthday) 76 yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Months | Days | | Hours | | Min. | | |
| IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | |
| Months | Days | | | | | | | | | | | | | | | | | | |
| | Hours | | | | | | | | | | | | | | | | | | |
| | Min. | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Church Creek | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | | | | | |
| 13. FATHER'S NAME Edwin B. Jones | | | | | | 14. MOTHER'S MAIDEN NAME Margaret Ellen Richardson | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Miss Ellen Banning, Church Creek, Md. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolus 9040 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture neck l. femur. (a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hours. 17 days. | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell in home. | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 8 PM e.m. Feb. 1, 1966 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) Church Creek, Dor., Md. | | (County) Dorchester | | (State) Md. | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John Mace Jr.</i> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 2/19/66 | | | | | | | | | | | |
| EXAMINER'S NAME (Type) John Mace Jr. M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| | | | | Address (Street, city, town, or county) Cambridge, Md. | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF Feb. 20, 1966 | | 22c. NAME OF CEMETERY OR CREMATORY old Trinity Churchyard | | 22d. LOCATION (City, town, or county) (State) Church Creek, Md. | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR <i>Samuel R. Thomas</i> | | | | ADDRESS Cambridge, Md. | | | | 24a. REC'D BY REGISTRAR FEB 21 1966 | | 24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | | | |

MEDICAL CERTIFICATION

ISSUE

ORDER

November

1950

through 1950

1950-1951

1951

1951-1952

1952-1953

1953-1954

1954-1955

1955-1956

1956-1957

James M. [Signature]

1957-1958

1958-1959

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Dorchester | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland | | b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge | | c. LENGTH OF STAY IN lb 18 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital | | d. STREET ADDRESS William St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Pearl M. Brittingham | | 4. DATE OF DEATH Month February Day 17 Year 1966 | | | |
| 5. SEX f | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/18/98 | 9. AGE (In years last birthday) 67 yrs. | IF UNDER 1 YEAR Months 17 Days 19 Hours 66 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) factory worker | | 10b. KIND OF BUSINESS OR INDUSTRY Pocomoke-Rural | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Gordon Redden | | 14. MOTHER'S MAIDEN NAME Savannah Ward | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unk | | 16. SOCIAL SECURITY NO. unk | | 17. INDEMNITY ADDRESS Mr. Robert J. Redden (Brother) R.D.#2 Eden Medical Records, ESSH Cambridge, Md. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 975x Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | INTERVAL BETWEEN ONSET AND DEATH INSTANT |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) WALKED INTO RIVER | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 5.30PM p.m. 2/17/66 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RIVER | 20f. (City or town) CAMBRIDGE | (County) DOR. MD. (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Mace Jr. | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED 22x18x66 2/18/66 | |
| EXAMINER'S NAME (Type) JOHN MACE JR. | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Feb. 21/1966 | 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | 23d. LOCATION (City, town or county) (State) Salisbury, Maryland | | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY | | ADDRESS SALISBURY, MARYLAND | | 25a. REC'D BY REGISTRAR FEB 23 1966 | 25b. REGISTRAR'S SIGNATURE J Charles Judge |

US200

2001

William St.

Boonora-Hur-I

Mr. Robert J. Heiden (Brother) B.O. #2848

INSTANT

VALUED INTO ALIVE

CANADIAN CORP. INC.

X-111-11

2. 2001 21/00

21XVXX

John H. de la.

Calisbury, Maryland

Burial Feb. 21/1966 Persons Cemetery

HOLLIDAY & COMPANY CALISBURY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

02258

Item 2 Film G375 3/31/66 mh

Reg. Dist. No. 02212

| | | | |
|---|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY DOR. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILLIAMSBURG | |
| c. LENGTH OF STAY IN 1b 5 DAYS | | d. STREET ADDRESS ST. MARYS REST HOUSE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CAMBRIDGE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) GEORGIA First Middle Last | | 4. DATE OF DEATH 2 Month 1 Day 1966 Year | |
| 5. SEX F | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-30-07 |
| 9. AGE (In years last birthday) 58 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Conley | | 14. MOTHER'S MAIDEN NAME Joseph Conley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. RECORDS CAMBRIDGE HOSPITAL | |
| 17. INFORMANT RECORDS CAMBRIDGE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 9047 DUE TO FRACTURE NECK FEMUR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 DAYS DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL IN NURSING HOME | |
| 20c. TIME OF INJURY Month, Day, Year 11/28/66 Hour a. m. p. m. | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) REST HOME | | 20f. (City or town) (County) (State) WILLIAMSBURG DOR. MD. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Mace Jr | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) JOHN MACE JR | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Buried | | 22b. DATE THEREOF 3-8-66 | |
| 22c. NAME OF CEMETERY OR CREMATORY Bethel Cem | | 22d. LOCATION (City, town, or county) (State) Cambridge Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Booker M West | | 24a. REC'D BY REGISTRAR Feb 10 1966 | |
| | | 24b. REGISTRAR'S SIGNATURE James Judge | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
NEW YORK

258

1915

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE

MD

PERCEPTEUR

WILKES BARRE

2 DAYS

CAMBRIDGE

CAMBRIDGE HOSPITAL

ST MARKS REST HOUSE

CANAL

GEORGIA

F

WILKES

30

U.S.A.

MARYLAND

HOME

NO

RECORD CAMBRIDGE HOSPITAL

UREMIA

2 DAYS

FRACURE NECK FEMUR

2 DAYS

X

FELL IN PAVING HOME

11/21/15 - 1st TIME HOME BIRMINGHAM DOG NO

21/KC

10th MARCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
|---|--|---------------------------|---|---|--|---|--|--|--|---|
| 02259 | | | | | 02213 | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>yes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Maryland Hospital</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>1002 Pine Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>John Camper</u> | | | First Middle Last | | 4. DATE OF DEATH <u>February 23, 1966</u> | | Month Day Year | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>E</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1898</u> | | 9. AGE (in years last birthday) <u>67</u> yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>unk.</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WWI</u> | | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Dolores Camper</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>February 21, 1966</u> , to <u>Feb. 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 23, 1966</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE <u>J. Edwin Fassett</u> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>2-23-66</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u> | | | | | 22d. ADDRESS <u>727 Pine St., Cambridge, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>Mar 6-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cem</u> | | 23d. LOCATION (City, town or county) (State) <u>Cont. Md</u> | | | |
| 24. FUNERAL DIRECTOR <u>Booker M. West</u> ADDRESS | | | | | 25a. REC'D BY REGISTRAR <u>DATE MAR 7 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Joseph</u> | | | |

61380

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 14 Hrs. 55 Min d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital Inc. | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Vienna d. STREET ADDRESS Box 183 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Boy | | 4. DATE OF DEATH Month February Day 5 Year 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 4, 1966 |
| 9. AGE (in years last birthday) 14 | | IF UNDER 1 YEAR Months 14 Days 55 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Dorchester Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Richard Daniel Robinson | | 14. MOTHER'S MAIDEN NAME Shirley Mae Carr | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mother | | Address Box 183 Vienna Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Subdural hemorrhage - Ruptured 7605 DUE TO (b) 2. Respiratory distress Syndrome (c) (Hyaline membrane disease) Bleach pneumonia & obstructive pulmonary disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 4 , 19 66 to Feb 5 , 19 66 , that (I) (we) last saw the deceased alive on Feb 4 , 19 66 , and that death occurred at 8:45 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE [Signature] | | 22b. DATE SIGNED 2-8-66 | |
| 22c. PHYSICIAN'S NAME (Type) Dr J Edwin Fassett | | 22d. ADDRESS 727 Pine St Cambridge Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2-5-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Methodist Church Cemetery | | 23d. LOCATION (City, town or county) (State) Vienna | |
| 24. FUNERAL DIRECTOR Richard Robinson | | 25a. REC'D BY REGISTRAR Feb 10 1966 | |
| Box 183 Vienna Md. | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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61256

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02261

CERTIFICATE OF DEATH

02216

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISEIELD 19-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL | | d. STREET ADDRESS PAPER STREET | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle WESLEY Last COLLINS | | 4. DATE OF DEATH Month FEBRUARY Day 4 Year 1966 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 08-26-07 |
| 9. AGE (In years last birthday) 58 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY -- | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES COLLINS | | 14. MOTHER'S MAIDEN NAME NEOME GILES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218-05-2958 | |
| 17. INFORMANT RECORDS- EASTERN SHORE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS AND HYPERTENSION DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 24 HRS. 10 YRS. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from JAN. 18, 1966 , to FEB. 4, 1966 that (I) (we) last saw the deceased alive on FEB. 4, 1966 , and that death occurred at 3:28 PM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE C F Barroso | | 22b. DATE SIGNED 2-4-66 | |
| 22c. PHYSICIAN'S NAME (Type) C. F. BARROSO, M. D. | | 22d. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, DOR. CO., MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIED | 23b. DATE THEREOF 2/9/66 | 23c. NAME OF CEMETERY OR CREMATORY Asbury | 23d. LOCATION (City or town) (County) (State) Crisfield MD |
| 24. FUNERAL DIRECTOR Anthony E. Ward Crisfield MD. | | 25a. REC'D BY REGISTRAR FEB 10 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in every event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|---|--|--|--|----------------------------|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 02262 | | | | | | | | | | | |
| 02217 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u> d. STREET ADDRESS <u>09-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>James Herman Conway</u> | | | First <u>James</u> Middle <u>Herman</u> Last <u>Conway</u> | | 4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1966</u> | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1/13/1885</u> | | 9. AGE (In years last birthday) <u>81</u> yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | |
| 13. FATHER'S NAME <u>Algie Conway</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Thompson</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Alma Conway, Vienna, Md</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left lung & metastasis</u> 163x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <u>Coronary heart disease</u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/30/57</u> , 19 <u>57</u> to <u>2/24/</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/24/</u> , 19 <u>66</u> , and that death occurred at <u>7:45 A</u> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Albert E. Bunker M.D.</u> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>2/25/66</u> | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Albert E. Bunker M.D.</u> | | | | | 22d. ADDRESS <u>Cambridge - Maryland</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>2/26/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u> | | 23d. LOCATION (City, town or county) (State) <u>East New Market Md</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Charles H. Hurloughby, East New Market</u> | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | | DATE <u>MAR 2 1966</u> | | | | | | |

05215

05215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|----------------------------------|---|---|--|---|---|---|--|
| 02263 | | | | | 03697 | | | | |
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge c. LENGTH OF STAY IN 1b 11 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Cambridge d. STREET ADDRESS RFD 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Nettie | | | First Middle Last Cooper | | | 4. DATE OF DEATH Month Day Year February 27, 19 66 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 20, 1899 | | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 66 yrs. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10b. KIND OF BUSINESS OR INDUSTRY Laborer | | | 11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Burroughs | | | | | 14. MOTHER'S MAIDEN NAME Ellen Thomas | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-10-6437 | | 17. INFORMANT Address Medical Records, ESSH, Cambridge, Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C V A with hypertension DUE TO (c) Diabetes mellitus | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Hours Years Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 15, 1966 to Feb. 27, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 26, 1966 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Rene E. Smith | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 2/27/1966 | | |
| 22c. PHYSICIAN'S NAME (Type) RENE E. SMITH, M.D. | | | | | 22d. ADDRESS Cambridge, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 3/6/1966 | | 23c. NAME OF CEMETERY OR CREMATORY Aireys Cemetery | | 23d. LOCATION (City, town or county) (State) Dorchester County, Md. | | |
| 24. FUNERAL DIRECTOR Herbert M. Clark Jr. | | | | | ADDRESS Cambridge, Md. | | 25a. REC'D BY REGISTRAR DATE MAR 8 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge 09-1 | |
| c. LENGTH OF STAY IN 1b 7 yrs. | | d. STREET ADDRESS 506 Pine Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 506 Pine Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Anna Middle Stothoff Last Cornish | | 4. DATE OF DEATH Month Feb. Day 12 Year 1966 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 27, 1897 |
| 9. AGE (in years last birthday) 68 yrs. | | IF UNDER 12 YEARS: Months 12 Days 19 Min. 68 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife / Lab. | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) New Haven, Conn. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Stothoff | | 14. MOTHER'S MAIDEN NAME Rachel Set Stothoff | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) ----- | | 16. SOCIAL SECURITY NO. 214-34-5306 | |
| 17. INFORMANT Russell Cornish | | Address Cambridge, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain damage result of old injury 4201 DUE TO (b) Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Brain damage result of old injury | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1964 to Feb 12, 1966 , that (I) (we) last saw the deceased alive on Feb 12, 1966 , and that death occurred at M , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | 22b. DATE SIGNED 2-12-66 | |
| 22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D. | | 22d. ADDRESS 727 Pine Street Cambridge, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 2/15/66 | 23c. NAME OF CEMETERY OR CREMATORY Waugh | 23d. LOCATION (City, town or county) (State) Cambridge, Md. |
| 24. FUNERAL DIRECTOR <i>[Signature]</i> Cambridge, Md. | | 25a. REC'D BY REGISTRAR FEB 18 1966 | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

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HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|--|---|
| 02265 | | 02219 | |
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 407 Charles Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Roman Middle Lee Last Cornish | | 4. DATE OF DEATH Month Feb. Day 16 Year 1966 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 10, 1924 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 9. AGE (In years last birthday) 41 yrs. |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Fred. Cornish | | 14. MOTHER'S MAIDEN NAME Mary Jane | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) -WW II | | 16. SOCIAL SECURITY NO. 220-12-1690 | |
| 17. INFORMANT Hattie Cornish | | Address Cambridge, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 5 hours. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Mace, Jr. | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John Mace, Jr. M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/19/66 | |
| | | Address (Street, city, town, or county) Cambridge, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 2/20/66 | 23c. NAME OF CEMETERY OR CREMATORY Old Field | 23d. LOCATION (City, town or county) (State) Dorchester Co., Md. |
| 24. FUNERAL DIRECTOR Ludwick C. Davis | | ADDRESS Cambridge, Md. | |
| 25a. REC'D BY REGISTRAR FEB 25 1966 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | |

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John Smith

John Smith, Jr.

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Cambridge, MA

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02266

02220

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN lb 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge, Maryland Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golden Hill d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last EDGAR CHARLES CUSICK | | | 4. DATE OF DEATH Month Day Year February 28, 1966 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 21, 1892 | 9. AGE (In years last birthday) 73 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well Driller | | 10b. KIND OF BUSINESS OR INDUSTRY Water Wells | | 11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland | | | |
| 13. FATHER'S NAME William J. Cusick | | | 14. MOTHER'S MAIDEN NAME Helen Virginia Vane | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Miss Norma Lee Cusick, Golden Hill, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral 442X DUE TO Arterio-sclerotic C.V.R.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 mo. ? | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 1 , 19 66 , to Feb 28 , 19 66 , that (I) (we) last saw the deceased alive on 2/28 , 19 66 , and that death occurred at 12 noon M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE James U. Thompson M.D. | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Locust St., Cambridge Maryland 21613 | | | | |
| 22c. PHYSICIAN'S NAME (Type) James U. Thompson, MD | | | 22b. DATE THEREOF Mar 2, 1966 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park | | 23d. LOCATION (City, town or county) (State) Cambridge, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS LeCompte Funeral Service, Cambridge, Maryland | | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 3 1966 Charles Judge | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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London, Maryland

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COSTON

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EDGAR

February 28, 68

Dec. 21, 1962

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Water Wells

Oil Wells

Dorchester Co., Maryland

Helan Virginia Lane

William J. Gustin

Miss Norma Lee Gustin, Golden Hill, Maryland

Unknown

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Yes

*Chambers
Water Wells*

3/1/68

Local St. Charles Maryland 21043

James V. Thompson, III

Mar 2, 1968 Dorchester Memorial Park Cambridge, Maryland

Lacrosse Service, Cambridge, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02267

02221

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) | | | |
| a. COUNTY Dorchester | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge | | a. STATE Maryland | | b. COUNTY Dorchester | |
| c. LENGTH OF STAY IN 1b 5 Days | | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge | | d. STREET ADDRESS 616 Academy Street | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First Linda | | Middle Mae | | Last Elzey | | Month Feb. 5, 1966 | |
| Day 19 | | Year 1966 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 4, 1954 | |
| 9. AGE (In years last birthday) 11 yrs. | | IF UNDER 1 YEAR Months 11 Days 11 | | IF UNDER 24 HRS. Hours 11 Min. 11 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | | | 10b. KIND OF BUSINESS OR INDUSTRY Student | | 11. BIRTHPLACE (County & State, or foreign country) Cambridge | |
| 12. CITIZEN OF WHAT COUNTRY U.S. | | | | | | | |
| 13. FATHER'S NAME Robert Lee Elzey | | | | 14. MOTHER'S MAIDEN NAME Betty Mae Wheatley | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | | |
| 17. INFORMANT Robert Lee Elzey, Cambridge, Md. | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock, post-operative, 551X DUE TO (b) following appendectomy DUE TO (c) Gastric dilatation | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 1 1966 to Feb 5 1966, that (I) (we) saw the deceased alive on Feb 5 1966 and that death occurred at 2:00 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Lewis M. Burdette M.D. | | | | 22b. DATE SIGNED 2/5/66 | | | |
| 22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette | | | | 22d. ADDRESS 601 Locust St. Cambridge, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Feb. 7, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park Cambridge, Md. | | 23d. LOCATION (City, town or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE James H. Thomas | | | | 25. REC'D BY REGISTRAR FEB 10 1966 | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1888

CERTIFICATE OF DEATH

1888

Notary Public

Myself

Witness

Deceased

Age

Gender

Place of Birth

Place of Death

Date

Time

Place

Witness

Signature

Witness

Deceased

Witness

Notary Public

Notary Public

Myself

Deceased

Age

Gender

Place of Birth

Place of Death

Date

Time

Place

Witness

Signature

Deceased

Age

Gender

Place of Birth

Place of Death

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02268

CERTIFICATE OF DEATH

02223

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | |
| c. LENGTH OF STAY IN 1b <u>3 mos.</u> | | d. STREET ADDRESS <u>700 Bailey Rd.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Elsie</u> First Middle Last <u>Gluck</u> | | 4. DATE OF DEATH <u>Feb. 25</u> 19 <u>66</u> Month Day Year | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-1-1887</u> 19 <u>87</u> Yrs. |
| 9. AGE (In years last birthday) <u>79</u> Yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>?</u> | | 13. FATHER'S NAME <u>—</u> | |
| 14. MOTHER'S MAIDEN NAME <u>—</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | |
| 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Records - Hospital</u> Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic glomerulonephritis</u> DUE TO (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 year</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that the (this hospital) attended the deceased from <u>Jan. 30</u> , 19 <u>65</u> , to <u>Feb. 25</u> , 19 <u>66</u> , that it (we) lost saw the deceased alive on <u>Feb. 23</u> , 19 <u>66</u> , and that death occurred at <u>0100</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Martin M. Nosen, M.D.</u> | | 22b. DATE SIGNED <u>25 Feb 66</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Feb 27, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Cambridge, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>LECOMPT FURNERAL SER. CAMBRIDGE MARYLAND</u> | | 25a. REC'D BY REGISTRAR <u>MAR 1 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

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University of Cambridge

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02269

02224

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | | |
| c. LENGTH OF STAY IN 1b <u>6 mos.</u> | | | | 20-2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u> | | | | d. STREET ADDRESS | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mackenzie L. Goldsborough</u> | | | | 4. DATE OF DEATH <u>Feb. 16</u> 19 <u>66</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6-15-04</u> | |
| | | | | 9. AGE (In years last birthday) <u>61</u> yrs. | | IF UNDER 1 YEAR: Months <u></u> Days <u></u> IF UNDER 24 HRS: Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Mackenzie Goldsborough</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Julia Fleming</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | |
| 17. INFORMANT <u>Records - Eastern Shore State Hosp.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1) Chronic myelitis</u> DUE TO <u>357X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cervical spine (4th) compression</u> DUE TO } (c) <u>2) Pulmonary embolism</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>7 years -</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 6, 1965</u> to <u>Feb. 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 16/66</u> 19 <u>66</u> , and that death occurred at <u>3:44</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Carlos F Barroso</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO MD</u> | | | | 22d. ADDRESS <u>E.S. Hospital, Cambridge Md.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>2-17-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Dorchester D.C.</u> | |
| 24. FUNERAL DIRECTOR <u>Charles Judge</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>FEB 21 1966</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|---|--|--|--|--|
| 02270 | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | 02225 | | | | |
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN life Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 212 Virginia Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First THERESA Middle A. Last HENRY | | | | | 4. DATE OF DEATH Month February Day 24 Year 1966 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 8, 1963 | | 9. AGE (In years last birthday) 2 yrs. | | IF UNDER 1 YEAR Months 2 Days 0 | | IF UNDER 24 HRS. Hours 0 Min. 0 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Cambridge, Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME Emerson T. Henry | | | | | 14. MOTHER'S MAIDEN NAME Kitty Moore | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mr. Emerson T. Henry, Cambridge, Maryland | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute tracheo-laryngitis 474X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.) | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John Mace Jr. | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | DATE SIGNED 2/25/66 | | | | |
| EXAMINER'S NAME (Type) John Mace Jr. M.D. | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | Address (Street, city, town, or county) Cambridge, Md. | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb 27, 1966 | | 22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park | | | | 22d. LOCATION (City, town, or county) (State) Cambridge, Maryland | | | | | | |
| 23. FUNERAL DIRECTOR ADDRESS LeCompte Funeral Service, Cambridge, Maryland | | | | | 24a. REC'D BY REGISTRAR MAR 1 1966 | | 24b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | | | |

MEDICAL CERTIFICATION

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME
5M 1/63

| <div> <div>02271</div> <div> <div>02226</div> <div>07-1</div> </div> </div> <div> <div> <div>02271</div> <div>02226</div> </div> <div> <div>02271</div> <div>02226</div> </div> </div> | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge-Maryland Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Emco</u> Middle <u>Jacobs</u> Last _____ 4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1966</u> | | | | 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 23, 1891</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____ | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> 11. BIRTHPLACE (State or foreign country) <u>Oregon, Illinois</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Christian Jacobs</u> 14. MOTHER'S MAIDEN NAME <u>Bessie Schrowder</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>WW I 217-36-0876</u> 17. INFORMANT <u>Mrs. Elizabeth Gorman, Hurlock, Maryland</u> | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/11/66</u> DATE SIGNED _____ Address (Street, city, town, or county) <u>Cambridge, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Feb. 13, 1966</u> 22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u> 22d. LOCATION (City, town, or county) <u>East New Market, Maryland</u> (State) _____ | | | | 23. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Maryland</u> ADDRESS _____ 24a. REC'D BY REGISTRAR <u>FEB 18 1966</u> DATE _____ 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|---|--|---|--|
| 02272 CERTIFICATE OF DEATH 02227 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge | | | | c. LENGTH OF STAY IN 1b Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge 09-1 | | | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 704 High Street | | | | | | d. STREET ADDRESS 704 High Street | | | | | |
| 3. NAME OF DECEASED (Type or print) First Natasha Middle Johnson Last Johnson | | | | | | 4. DATE OF DEATH Month Feb. Day 3 Year 19 66 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 12, 1966 | | 9. AGE (In years last birthday) yrs. 22 | | IF UNDER 1 YEAR Months 22 Days 22 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Charles Jackson | | | | | | 14. MOTHER'S MAIDEN NAME Pauline Johnson | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Name Pauline Johnson Address Cambridge, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Virus Infection 7630 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastroenteritis 21. I certify that (I) (this hospital) attended the deceased from Feb 2, 1966 , to February 19, 1966 that (I) (we) last saw the deceased alive on Feb 3, 1966 , and that death occurred at 7 PM , from the causes and on the date stated above. 22a. SIGNATURE J. Edwin Fasett 22b. DATE SIGNED 2-3-66 22c. PHYSICIAN'S NAME (Type) J. Edwin Fasett, M.D. 22d. ADDRESS 727 Pine Street Cambridge, Md. 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. (City or town) (County) (State) 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/7/66 23c. NAME OF CEMETERY OR CREMATORY Aireys 23d. LOCATION (City, town or county) (State) Dorchester Co., Md. 24. FUNERAL DIRECTOR Julius C. Delaney ADDRESS Cambridge, Md. 25a. REC'D BY REGISTRAR FEB 8 1966 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | |

6-152382

02283

02283

Det. Chester
Life

For High Speed
Johnston

Jan. 12, 1966
Johnston, N.H.

Charles Jackson
Cambridge, Mass.

Johnston, N.H.

Johnston, N.H.

Johnston, N.H.

Johnston, N.H.

Johnston, N.H.

Johnston, N.H.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
5M 1/65

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 02273 | | Item #9 Film #G373 2/10/66 | | 02228 | | | | | |
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge-Rural | | | c. LENGTH OF STAY IN lb Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge-Rural 09-1 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Annie Middle Stanley Last Jones | | | 4. DATE OF DEATH Month Feb. Day 2 Year 1966 | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Apr. 20, 1892 74 yrs. | | 9. AGE (In years last birthday) IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Richard Stanley | | | | | 14. MOTHER'S MAIDEN NAME Mary Wilson | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Phillip Lee Jones Cambridge, Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Instant | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 2Df. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>John Mace, Jr.</i> | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) John Mace, Jr. | | | | | 22. DATE SIGNED Address (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/6/66 | | 23c. NAME OF CEMETERY OR CREMATORY Fork Neck | | 23d. LOCATION (City, town or county) (State) Dorchester Co., Md. | | | |
| 24. FUNERAL DIRECTOR <i>Richard C. DeBar</i> | | | | | 25a. REC'D BY REGISTRAR DATE FEB 8 1966 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |

02228

02223

Unidentified-Local

Life

Unidentified-Local

1892 74

Unidentified

Unidentified

Unidentified

Unidentified

[Handwritten signature]

John H. H. H.

John H. H. H.

John H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02274

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02229

| | | | | | | | |
|---|--|--|------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Q.A. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. CHESTERTOWN | | | |
| c. LENGTH OF STAY IN 1b 2 YRS. | | | | d. STREET ADDRESS 17-2 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) HARRY | | | First Middle Last KNIGHT | | | 4. DATE OF DEATH Month Day Year FEB. 17 19 66 | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12/5/78 | |
| 9. AGE (In years last birthday) 87 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) PA. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | 13. FATHER'S NAME WILLIAM KNIGHT | | | |
| 14. MOTHER'S MAIDEN NAME LOUISE MARKLEY | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. - | | | | 17. INFORMANT HOSPITAL RECORDS | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493x DUE TO General debility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/9 , 19 64 , to 2/17 , 19 66 , that (I) (we) last saw the deceased alive on 2/17 , 19 66 , and that death occurred at 1:10 P.M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Carlos F Barros | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 2/17/66 | |
| 22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROS O, M.D. | | | | 22d. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 2/21/1966 | | 23c. NAME OF CEMETERY OR CREMATORY WM. PENN CEMETERY | | 23d. LOCATION (City, town or county) (State) PHILADELPHIA, PENNA. | |
| 24. FUNERAL DIRECTOR LECOMPT FURNAL SERVICE, CAMBRIDGE, MD. | | | | 25a. REC'D BY REGISTRAR FEB 21 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION

252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

(M)

02275

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02231

| | | | |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital Inc. | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 514 Cedar St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Napoleon Troy Matthews | | 4. DATE OF DEATH February 17 19 66 | |
| 5. SEX male | 6. COLOR OR RACE colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 31-1966 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | 9. AGE (In years last birthday) 16 yrs. IF UNDER 1 YEAR: Months 16 Days 18 Hours 46 IF UNDER 24 HRS. Min. 46 |
| 11. BIRTHPLACE (County & State, or foreign country) Dorchester - Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Leroy Copes | | 14. MOTHER'S MAIDEN NAME Ardenia Lorraine Tilghman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Ardenia Matthews | | Address Cambridge, Maryland 514 Cedar St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 752X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 31 , 19 66 , to Feb. 17 , 19 66 , that (I) (we) last saw the deceased alive on Jan. 16 , 19 66 , and that death occurred at 6:15 M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Dr. J. Edwin Fassett | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Dr. J. Edwin Fassett | | 22d. ADDRESS 727 Pine St. Cambridge, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/18/1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery | | 23d. LOCATION (City, town or county) (State) Cambridge, Maryland | |
| 24. FUNERAL DIRECTOR Charles Judge | | 25a. REC'D BY REGISTRAR FEB 25 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

1529

652

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02276
CERTIFICATE OF DEATH

02232

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 5 Travers Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First FLORENTINE Middle HORTENSE Last MEREDITH | | | | 4. DATE OF DEATH Month February Day 22 Year 19 66 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 12, 1887 | |
| 9. AGE (In years last birthday) 78 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY Public School | | 11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME McKenney White Meredith | | | |
| 14. MOTHER'S MAIDEN NAME Rowena Gertrude Vickers | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) - - - | | | |
| 16. SOCIAL SECURITY NO. Unknown | | | | 17. INFORMANT Mr. Thomas V. Meredith, Cambridge, Maryland Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (e), stating the underlying cause last. DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Adenocarcinoma of sigmoid | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 22 1966 to Feb 22 1966 , that (I) (we) last saw the deceased alive on Feb 22 1966 , and that death occurred at 3:20 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Lewis M. Burdette M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 23 Feb 66 | |
| 22c. PHYSICIAN'S NAME (Type) Lewis M. Burdette | | | | 22d. ADDRESS 60 Locust St. Cambridge Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Feb 25, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park | | 23d. LOCATION (City, town or county) Cambridge, Maryland (State) _____ | |
| 24. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service, Cambridge, Maryland ADDRESS | | | | 25a. REC'D BY REGISTRAR WAR 1 1966 DATE | | 25b. REGISTRAR'S SIGNATURE William Judge | |

MEDICAL CERTIFICATION

03238

MEMORANDUM FOR THE DIRECTOR

03238



Director
Comptroller
Mr. Thomas F. Meredith, Chairman, Maryland
James Garfield Victoria
Daniel Tanager
White
Feb. 27, 1968
February 25, 1968
Maryland
USA

Feb 27, 1968
Maryland
James Garfield Victoria
Daniel Tanager
White
Feb. 27, 1968
February 25, 1968
Maryland
USA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02277

02233

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harlock</u> | | | | c. LENGTH OF STAY IN 1b <u>Months</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belle Haven Nursing Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Lillie Berridge Merrick</u> | | | | 4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1966</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/4/33</u> | |
| 9. AGE (In years last birthday) <u>32</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Cookman Berridge</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Emma Short</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>100</u> | | 17. INFORMANT <u>Mrs. Fulton Evans, Cambridge, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>4500</u> DUE TO <u>Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infection And Chronic Congestive Heart</u> DUE TO (c) <u>Generalized arteriosclerosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 yrs</u> <u>20 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left sided hemiplegia moderate</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/15/66</u> , 19 <u> </u> , to <u>2/16/66</u> , that (I) (we) last saw the deceased alive on <u>2/15/66</u> , 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | 22b. DATE SIGNED <u>2/17/66</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Harold R. Pummer</u> | |
| 22d. ADDRESS <u>Preston Maryland</u> | | | | 22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>2/18/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u> | | 23d. LOCATION (City, town or county) (State) <u>East New Market, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Ruth S. Kiloughy, East New Market</u> | | | | 25a. REC'D BY REGISTRAR <u>FEB 10 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

02283

155

Female white x male black
1/2 x 1/2 = 1/4

Goekman, J. C. 1904
No. 10

1/2 x 1/2 = 1/4
1/2 x 1/2 = 1/4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02273

02234

| | | | | | | | |
|---|--|--|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge (rural) | | | c. LENGTH OF STAY IN 1b 8 mos | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, 19-2 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Lillian Middle Miles Last Miles | | | | 4. DATE OF DEATH Month February Day 2 Year 19 66 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 01-28-81 | |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR Months 2 Days 19 Hours 66 Min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Benjamin Franklin Haynes | | | | 14. MOTHER'S MAIDEN NAME Nannie Lola Ward | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Records of the Eastern Shore State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic Brain Syndrome | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 05-19- , 19 65 , to 02-02- , 19 66 that (I) (we) last saw the deceased alive on 02-02- , 19 66 , and that death occurred at 6:20 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Felipe M. Dominguez M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 2-2-66 | |
| 22c. PHYSICIAN'S NAME (Type) FELIPE M. DOMINGUEZ M.D. | | | | 22d. ADDRESS E.S.S.H. | | | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 2/5/66 | | St. Paul Cemetery | | Morris MD | |
| 24. FUNERAL DIRECTOR Levin Wilson | | | | ADDRESS Princess Anne | | 25a. REC'D BY REGISTRAR Feb 8 1966 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

03234

UNITED STATES DEPARTMENT OF AGRICULTURE

03234

OFFICE OF THE SECRETARY
WASHINGTON, D. C.
January 10, 1911
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 7th inst. in relation to the matter of the proposed amendment to the act of March 3, 1879, relating to the sale of land in the public domain.

| | |
|--|--|
| The proposed amendment is as follows: | |
| "That the Secretary of the Interior be and he is hereby authorized to sell the same at public auction, to the highest bidder, for cash, in advance of delivery, and the proceeds of the sale to be paid into the Treasury of the United States, to be used for the purpose of purchasing land for the same purpose." | |
| The proposed amendment is in accordance with the recommendation of the Commission on the Public Land Survey, and is believed to be in the best interests of the Government. | |
| Very respectfully, Secretary of the Interior | |

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13

2

2

BP

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02279

02235

| | | | | | | | | | |
|--|--|----------------------------------|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 20 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Denton d. STREET ADDRESS 519 Franklin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Mary | | First Mary | | Middle Modesitt | | Last Modesitt | | 4. DATE OF DEATH Month February Day 9 Year 1966 | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 08-27-76 | | 9. AGE (In years last birthday) 89 yrs. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Moore | | | | 14. MOTHER'S MAIDEN NAME Emma Audrew | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Records | | Address Cambridge, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4341 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME, ARTERIOSCLEROSIS | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) JOHN MACE JR. | | | | M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED 2/10/66 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 23b. DATE THEREOF FEB. 12, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY SPRING HILL | | 23d. LOCATION (City, town or county) (State) LEASTON MD. | |
| 24. FUNERAL DIRECTOR <i>Virgil Moore</i> Denton | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE <i>Feb 10/66</i> FEB 15 1966 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

11528

20 0 Ys

08-27-70

CONGESTIVE HEART FAILURE

CHRONIC BRAIN SYNDROME, ATROPHIC

James
John [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|-------------------------------|--|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
| 02280 | | | | | 02236 | | | | | |
| Item #9 Film #0373 2/21/66 | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Madison d. STREET ADDRESS 09-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Maggie | | | First Middle Last | | 4. DATE OF DEATH Feb. 12, 1966 | | | Month Day Year | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 17, 1895 | | 9. AGE (In years last birthday) 70 21/12 yrs. IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME George Waters | | | | | 14. MOTHER'S MAIDEN NAME Caroline Waters | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. 212-16-7316 | | 17. INFORMANT Ida R. Opher 2431 W. Franklin St. Bal | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Ht. Disease 592X DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephritis, chronic DUE TO 5 yrs (c) 5 yrs | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs 5 yrs 5 yrs | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/13 , 19 56 , to 2/12 , 19 66 , that (I) (we) last saw the deceased alive on 2/11 , 19 66 , and that death occurred at 8 A.M. from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE Alfred Marynov | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 2/15/66 | | | |
| 22c. PHYSICIAN'S NAME (Type) Alfred Marynov, M.D. | | | | | 22d. ADDRESS 610 Race Street Cambridge, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 2/16/66 | | 23c. NAME OF CEMETERY OR CREMATORY Madison | | 23d. LOCATION (City, town or county) (State) Dorchester Co., Md. | | | |
| 24. FUNERAL DIRECTOR Julius C. Harris | | | | | ADDRESS Cambridge, Md. | | 25a. REC'D BY REGISTRAR FEB 18 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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General - Medical

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02281

02237

| | | | | | | | |
|--|---|--|---|--|--|--|--|
| 1. PLACE OF DEATH e. COUNTY Dorchester MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 50 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS Sandy Acres e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) RUTH SEWELL PAYNE | | 4. DATE OF DEATH Month February Day 22 Year 19 66 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 7, 1893 | 9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (County & State, or foreign country) Chicago, Illinois | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME George Ward Sewall | | | 14. MOTHER'S MAIDEN NAME Mary Franklin | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Mrs. Dorothy P. Book, Cambridge, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Metastases (umbilic) 170X DUE TO Ca nt. Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH acute chron | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 15, 1966 to Feb 21, 1966, that (I) (we) last saw the deceased alive on Feb 21, 1966, and that death occurred at 6 PM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE James U. Thompson | | 22b. DATE SIGNED Feb 21, 1966 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) James U. Thompson, MD | | 22d. ADDRESS Locust St., Cambridge, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Nov 24, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery | | | |
| | | 23d. LOCATION (City, town or county) (State) East New Market, Maryland | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS LeCompte Funeral Service, Cambridge, Maryland | | | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 25 1966 | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

02287

CERTIFICATE OF DEATH

02287

Residence

Residence

Residence

Occupation

Occupation

Occupation

Married Name

Married Name

Age

Age

Age

Sex

Sex

Sex

Place of Birth

Place of Birth

Place of Birth

Parents

Parents

Signature of Registrar

Center of Health (under)
Co. St. Louis

James H. Thompson
of St. Louis, Mo.
at New Market, Maryland
January 2, 1928
Lancaster Funeral Service, Lancaster, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

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|---|--|--|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____ | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>February 1, 1966</u> , to <u>Feb 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 13, 1966</u> , and that death occurred at _____ M, from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. _____ DATE SIGNED <u>2-13-66</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u> | | 22d. ADDRESS <u>727 Pine Street Cambridge, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>2/20/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Fork Neck</u> | |
| | | | | 23d. LOCATION (City, town or county) (State) <u>Dorchester Co., Md.</u> | |
| 24. FUNERAL DIRECTOR <i>[Signature]</i> | | ADDRESS <u>Cambridge, Md.</u> | | 25a. REC'D BY REGISTRAR <u>FEB 18 1966</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

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|---|--|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | |
| 02282 CERTIFICATE OF DEATH 02238 | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural- Fork Neck</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural- Fork Neck</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Maria</u> Middle <u>Elizabeth</u> Last <u>Pinder</u> | | | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>1966</u> | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Md.</u> | |
| 13. FATHER'S NAME <u>Henry Lee</u> | | | 14. MOTHER'S MAIDEN NAME <u>Harriett Stanley</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT <u>Herman Pinder</u> Address <u>Fork Neck, Md.</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|---|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 02283 | | | | | 02239 | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> | | | c. LENGTH OF STAY IN 1b <u>2 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pittsville</u> <u>22-2</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital</u> | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Louise</u> | | | First Middle Last <u>Ruark</u> | | 4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1966</u> | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-3-1879</u> | | 9. AGE (In years last birthday) <u>86</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u> | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>Medical Records</u> | | | Address <u>ESSH Cambridge</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>15 years.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <u>if</u> (this hospital) attended the deceased from <u>February 7, 1966</u> , to <u>February 10 1966</u> , that <u>if</u> (we) last saw the deceased alive on <u>February 10 1966</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Carlos F. Barros</u> | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>2/10/66</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u> | | | | | 22d. ADDRESS <u>ESSH Hospital CAMBRIDGE, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>2-13-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St STEPHENS</u> | | 23d. LOCATION (City, town or county) (State) <u>DELMAR-DEL</u> | | | |
| 24. FUNERAL DIRECTOR <u>Charles W. Manuel, Delmar</u> | | | | | 25a. REC'D BY REGISTRAR <u>FEB 15 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

03331

03331

4-3-10

UNKNOWN

UNKNOWN

BURRIDGE 2-13-66 ST STEPHENS DELMAR-DEL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crapple d. STREET ADDRESS R.F.D. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Agnes First Middle Last 4. DATE OF DEATH Feb. 4 19 66 Month Day Year | | 5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH June 1, 1923 9. AGE (In years last birthday) 42 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (County & State, or foreign country) Dorchester, Md. 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Howard Elliot 14. MOTHER'S MAIDEN NAME Viola Jenkins | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. ----- 17. INFORMANT Viola Jenkins Address Cambridge, md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Large Thoracic and Abdominal Aortic Aneurysm 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from Jan 29, 1966 , to February 4, 1966 , that (I) (we) last saw the deceased alive on February 4, 1966 , and that death occurred at M , from the causes and on the date stated above. 22a. SIGNATURE J. Edwin Fassett, Md. 22b. DATE SIGNED 2-4-66 22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, Md. 22d. ADDRESS 727 Pine Street Cambridge, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2/10/1966 23c. NAME OF CEMETERY OR CREMATORY Aireys 23d. LOCATION (City, town or county) (State) Dorchester Co. Md. | | 24. FUNERAL DIRECTOR Frederick O. Delany ADDRESS Cambridge, Md. 25a. REC'D BY REGISTRAR FEB 8 1966 25b. REGISTRAR'S SIGNATURE Frederick O. Delany | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to an event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|-------------------------------------|--|--|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 02285 | | | | | | 02242 | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HURLLOCK</u> c. LENGTH OF STAY IN 1b <u>5 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BELLE HAVEN NURSING HOME</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> 20-2 d. STREET ADDRESS <u>S. AURORA</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ALFRED HAMLIN SPIES</u> | | | | | | 4. DATE OF DEATH Month Day Year <u>FEB 15 1966</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>APRIL 8-1873</u> 92 yrs. | | 9. AGE (In years last birthday) <u>92</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER GEN WR</u> | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>ILLINOIS</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>HENRY SPIES</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>LOUISA WEBER</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>216-13-7536</u> | | 17. INFORMANT <u>HENRY A. SPIES</u> | | | | Address <u>EASTON, MD. R.D.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastase carcinoma of lung</u> 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of prostate</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>10 years.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 14</u> , 19 <u>66</u> , to <u>2-15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>February 15</u> 19 <u>66</u> , and that death occurred at <u>105</u> p.m., from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Carlos F Barroso</u> | | | | | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>February 16-1966</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>CARLOS F. BARROSO</u> | | | | | | 22d. ADDRESS <u>E.S.S. Hospital Cambridge Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>2-19-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u> | | | | 23d. LOCATION (City, town or county) (State) <u>EASTON MD</u> | | | |
| 24. FUNERAL DIRECTOR <u>Robert Clark</u> | | | | ADDRESS <u>Easton, Md</u> | | 25a. REC'D BY REGISTRAR <u>FEB 23 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

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LOUISA WEBER

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE Maryland b. COUNTY Dorchester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge (rural) | | c. LENGTH OF STAY IN 1b 4 months | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital | | d. STREET ADDRESS Hurlock (Chapline) | |
| 3. NAME OF DECEASED (Type or print) Minnie M. Lewis Spivey | | 4. DATE OF DEATH February 13 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-20-83 |
| 9. AGE (In years last birthday) 82 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Lewis | | 14. MOTHER'S MAIDEN NAME Florence Parrott | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Records of the Eastern Shore State Hospital | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 9037 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture neck femur DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell going to toilet | |
| 20c. TIME OF INJURY Month, Day, Year Feb 10/66 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital | | 20f. (City or town) (County) (State) Cambridge Dor. Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Mace Jr. | | 22. DATE SIGNED 2/14/66 | |
| EXAMINER'S NAME (Type) John Mace Jr. | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/16/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Stall Creek Cem | | 23d. LOCATION (City, town or county) (State) Federalsburg Md. | |
| 24. FUNERAL DIRECTOR Harvey Williams | | ADDRESS Federalsburg Md | |
| 25a. REC'D BY REGISTRAR FEB 18 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | | | | |
|--|------|------------------|---|--|--|--|---|--------------------------------------|--|---|-------|------|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u> c. LENGTH OF STAY IN 1b <u>6 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Belle Haven Nursing Home</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Preston</u> d. STREET ADDRESS <u>Maple Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Shaw</u> Last <u>Stout</u> | | | 4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1966</u> | | 5. SEX <u>Female</u> | | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | |
| 8. DATE OF BIRTH <u>5/3/1871</u> | | | 9. AGE (In years last birthday) <u>94</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Phila Pa</u> | |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>unknown</u> | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | | | | | | | |
| 16. SOCIAL SECURITY NO. <u>198-07-0391</u> | | | 17. INFORMANT <u>Mrs. Mariam Milligan, Maple Ave. Preston, Md.</u> | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure with</u> <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Auricular Fibrillation</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> <u>Generalized Arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>10 yrs</u> <u>20 yrs</u> | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia</u> | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from <u>6/21/63</u> , 19 <u>66</u> , to <u>2/10</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>2/9/66</u> , 19 <u>66</u> , and that death occurred at <u>10:50</u> from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE <u>Harold B. Plummer</u> | | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) <u>Harold B. Plummer M.D.</u> | | | | | | | | | | | | |
| 22d. ADDRESS <u>Preston Maryland</u> | | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | | | | | | | | | | |
| 23b. DATE THEREOF <u>2/14/1966</u> | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Harleigh Cemetery</u> | | | 23d. LOCATION (City, town or county) (State) <u>Camden, N. J.</u> | | | 24. FUNERAL DIRECTOR <u>Maurice E. Henneman and Son, Easton, Md.</u> | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR <u>FEB 14 1966</u> | | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 425 Camper St. | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 425 Camper St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Helen Elizabeth Thomas | | 4. DATE OF DEATH Month Feb. Day 21 Year 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 1, 1901 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Cook, Commercial | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jake Bargaen | | 14. MOTHER'S MAIDEN NAME Rosetta Greene | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. James Wheatley Cambridge, Md. | |
| 17. INFORMANT James Wheatley Cambridge, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type) John Mace Jr. M.D. | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md. | |
| 22. DATE SIGNED 2/22/66 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 2/25/66 | 23c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery | 23d. LOCATION (City, town or county) (State) Cambridge, Dor. Md. |
| 24. FUNERAL DIRECTOR Frederick O. Delair ADDRESS Cambridge, Md. | | 25a. REC'D BY REGISTRAR FEB 25 1966 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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MEDICAL EXAMINATION REPORT

05346

24

James

1/10/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02289

02246

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge | | c. LENGTH OF STAY IN 1b 1 week | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crocheron | | d. STREET ADDRESS None | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glasgow Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE ROBINSON TODD | | | | 4. DATE OF DEATH Month Day Year February 23 19 66 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 18, 1881 | |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Robinson | | | | 14. MOTHER'S MAIDEN NAME Isabella Willey | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Mr. Carroll H. Todd, Crocheron, Md. 21627 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Ht. Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH under |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, stool under | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from..... 2/11....., 1966, to..... 2/23....., 1966, that (I) (we) last saw the deceased alive on..... 2/14....., 1966, and that death occurred at 2 p.m., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Alfred R. Maryann M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 2/25/66 | |
| 22c. PHYSICIAN'S NAME (Type) ALFRED R. MARYANN | | | | 22d. ADDRESS 610 RALE ST, CAMBRIDGE MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Feb 25, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Bethany Churchyard | | 23d. LOCATION (City, town or county) (State) Crocheron, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS LeCompte Funeral Service, Cambridge, Maryland | | | | 25a. REC'D BY REGISTRAR MAR 1 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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Isabella Willes

William Robinson

Mr. Carroll H. Todd, Greenbelt, Md. 21527

Unknown

Isabella Willes, Maryland

Feb 2, 1962, Henry Greenbelt

Isabella

Isabella Willes, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 9 Film G574 2/28/66 mh

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03057

| | | | | | | | | | |
|--|----------------------------------|--|---|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY DORCHESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE c. LENGTH OF STAY IN b 4 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE d. STREET ADDRESS SHEPPARD AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HARRY W. TRAVERS | | 4. DATE OF DEATH Month Day Year FEBRUARY 18 19 66 | | | | | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1889 9/20/1889 | 9. AGE (In years last birthday) 77 yrs. | 10. UNDER 1 YEAR Months Days Hours Min. | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME WINFIELD TRAVERS | | 14. MOTHER'S MAIDEN NAME UNK | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 213-24-4482 | 17. INFORMANT MEDICAL RECORDS, ESSH, CAMBRIDGE, MD |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septicemia and infection of the right foot | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (X) (this hospital) attended the deceased from 2/26/62 , 19 62 , to 2/18/ , 19 66 , that (X) (we) last saw the deceased alive on 2/18 , 19 66 , and that death occurred at 9:15 M , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE James F Smith | | | | 22b. DATE SIGNED 2/18/66 | | 22c. PHYSICIAN'S NAME (Type) JAMES SMITH MD | | 22d. ADDRESS Eastern Shore State Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Feb 21 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery | | 23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland | | | |
| 24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland | | | | 25a. REC'D BY REGISTRAR DATE FEB 21 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|---|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 02291 | | | | | 02247 | | | | |
| 1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MD. b. COUNTY CAROLINE ✓ | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHOP TAN K | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL | | | | | d. STREET ADDRESS 05-2 | | | | |
| 3. NAME OF DECEASED (Type or print) First LEE Middle AVERY Last WALDRON | | | | | 4. DATE OF DEATH Month FEB. Day 14 Year 19 66 | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/4/94 | | 9. AGE (In years last birthday) 71 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC, CARPENTER | | 10b. KIND OF BUSINESS OR INDUSTRY Garage | | 11. BIRTHPLACE (County & State, or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13. FATHER'S NAME ELMER WALDRON | | | | | 14. MOTHER'S MAIDEN NAME NORA BUCKLEY | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | | | | 16. SOCIAL SECURITY NO. DISCH. 1919 WWI 213-16-8297 | | 17. INFORMANT HOSPITAL RECORDS | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERAL DEBILITY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH one day 5 years | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/6 , 19 63 , to 2/14 , 19 66 , that (I) (we) last saw the deceased alive on 2/14 , 19 66 , and that death occurred at 1:30 M., from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Carlos F. Barros | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> P.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 2/14/66 | | |
| 22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO | | | | | 22d. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2-17-66 | | 23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery | | 23d. LOCATION (City, town or county) (State) Near Preston, Maryland | | | |
| 24. FUNERAL DIRECTOR Frankston Funeral Home Federalsburg Md | | | | | ADDRESS DATE FEB 18 1966 | | 25a. REC'D BY REGISTRAR Charles Judge | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |

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VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|---|---|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 02292 | | | | | 02248 | | | | |
| 1. PLACE OF DEATH a. COUNTY DORCHESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE c. LENGTH OF STAY IN 1b 3 1/2 YRS. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL | | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MD. b. COUNTY WICOMICO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 102 E. ISABELLA ST., SALISBURY 22-2 d. STREET ADDRESS 102 E. ISABELLA ST., SALISBURY 22-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First KATHRYN Middle WICKS Last WICKS | | | 4. DATE OF DEATH Month FEB. 3 Day 19 66 Year 19 66 | | | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9/12/86 | | 9. AGE (In years last birthday) 79 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) MD. (Wor. Co.) | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME ALEXANDER POWELL | | | | 14. MOTHER'S MAIDEN NAME SARAH ELLEN TULL | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT HOSPITAL RECORDS Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.V.A. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/3 , 19 66 , to 2/3 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/3 , 19 66 , and that death occurred at 9:30M , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Felipe M. Dominguez M.D. 22c. PHYSICIAN'S NAME (Type) FELIPE M. DOMINGUEZ | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD. | | 22b. DATE SIGNED 2/3/66 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Feb. 9/1966 | | 23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery | | 23d. LOCATION (City, town or county) (State) Near Eden, Maryland | | | |
| 24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY, MARYLAND | | | | 25a. REC'D BY REGISTRAR FEB 15 1966 DATE | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

West Eden, Maryland

Oliver Cemetery

Burial Sep. 9, 1966

HOLLOWAY & COMPANY BALTIMORE, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 603 Schoolhouse Lane | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 603 Schoolhouse Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) Ernest Monroe Wilkins | | | | | 4. DATE OF DEATH Feb. 17, 1966 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Apr. 12, 1908 | | 9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Isiah Wilkins | | | | | 14. MOTHER'S MAIDEN NAME Laura F. Cornish | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II-- | | | | | 16. SOCIAL SECURITY NO. 217-10-8482 | | 17. INFORMANT Agnes Henry Address Cambridge, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinomatosis 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from September 1, 1965 , to Feb. 17, 1966 , that (I) (we) last saw the deceased alive on Feb. 17, 1966 , and that death occurred at 7 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE J. Edwin Fassett | | | | | 22b. DATE SIGNED 2-17-66 | | | | |
| 22c. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D. | | | | | 22d. ADDRESS 727 Pine Street Cambridge, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 2/20/66 | | 23c. NAME OF CEMETERY OR CREMATORY Bethel | | 23d. LOCATION (City, town or county) (State) Cambridge, Md. | | | |
| 24. FUNERAL DIRECTOR Judith C. Blair ADDRESS Cambridge, Md. | | | | | 25a. REC'D BY REGISTRAR FEB 25 1966 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 20b Film G375 2/21/66 TT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02294

02250

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|----------------------------------|--|---|--|-------------------------------------|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge (rural) c. LENGTH OF STAY IN b 3 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Hill d. STREET ADDRESS Box 55 a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Thomas Christopher Williams | | 4. DATE OF DEATH February 12 19 66 | | 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-03-91 | | 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months Oeys Hours Min. | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) North Carolina | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | | |
| 13. FATHER'S NAME Joseph Williams | | | | 14. MOTHER'S MAIDEN NAME Anna Polk | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1919 | | | | 16. SOCIAL SECURITY NO. 222-05-4574 | | | | 17. INFORMANT Records of the Eastern Shore State Hospital | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hematoma con- 9047 Conditions, if any, which gave rise to immediate causa (a), stating the underlying cause last. (b) placental by bronchopneumonia DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> Fall: hit door frame | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year 11:35 a.m. 1-16 19 66 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Eastern Shore State Hospital | | | | 20f. (City or town) (County) (State) Cambridge Md | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | 22. DATE SIGNED 2-13-66 | | | | | | | | | | | |
| ACTUAL SIGNATURE B. W. Rieckert | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Address (Street, city, town, or county) E. New Market Md | | | | | | | | | | | |
| EXAMINER'S NAME (Type) B. W. Rieckert | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 2/16/66 | | | | 23c. NAME OF CEMETERY OR CREMATORY Fairmount | | | | 23d. LOCATION (City, town or county) (State) Fairmount Md | | | | | | | |
| 24. FUNERAL DIRECTOR Anthony E. Warrington Md | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR FEB 15 1966 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | |

0537

1250

Box 22

W

[Faint, mostly illegible text throughout the page, possibly bleed-through from the reverse side. Some words like "Box 22" and "W" are more distinct.]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|--|--------------------------------------|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 02295 CERTIFICATE OF DEATH 02251 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>E.S.S.H.</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>Route 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Elbert</u> First <u>Williamson</u> Middle <u>Williamson</u> Last <u>Williamson</u> | | | | | 4. DATE OF DEATH <u>2</u> Month <u>7</u> Day <u>1966</u> | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-23-10</u> | | 9. AGE (In years last birthday) <u>56</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Wick. Galestown, Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Elijah Williamson</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Lona Hankford Salisbury, Md.</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. <u>218-14-2478</u> | | 17. <u>Informant</u> <u>Mrs. Earl White (Daughter)</u> Address <u>R.D. #2 Eastern Shore Hosp Medical Records</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> <u>223X</u> DUE TO (b) <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Meningioma</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (this hospital) attended the deceased from <u>6-19</u> , 19 <u>65</u> to <u>2-7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-7</u> , 19 <u>66</u> and that death occurred at <u>3:20</u> AM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>James F. Smith</u> | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>2-7-66</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>James F. Smith</u> | | | | | 22d. ADDRESS <u>Eastern Shore State Hospital</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Feb. 10/1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Siloam Cemetery</u> | | | 23d. LOCATION (City, town or county) (State) <u>Siloam, Maryland</u> | | |
| 24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u> | | | | | 25a. REC'D BY REGISTRAR <u>Feb 10 1966</u> DATE | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

HOLLIS & COMPANY, BALTIMORE, MARYLAND

Buried Feb. 10/1966 Wilson Cemetery

Baltimore, Maryland

James F. Smith

James F. Smith

2-7-66

6-17-66

2-7-66

2-7-66

Maria Brown

Central Avenue

Agitation

2-8-10-2478

See Entry 10 (Baltimore) 2. D. 1

Baltimore, Md.

M

W

X

1-23-10

Albert

William

2

7

66

3223

Carriage

Clasp

Knife

William

Baltimore

2523

W.C. 100

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02296

02252

| | | | | | | | | | | | | | | | |
|--|------------------|---|--|---|---|---|---|---|--|-----------------|------------------|--------|------|-------|------|
| 1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester | | | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hudson | | | c. LENGTH OF STAY IN 1b about 50 yrs | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hudson | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD #3 | | | | d. STREET ADDRESS RFD #3 | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First WALTER Middle S. Last WINGATE | | | | 4. DATE OF DEATH Month February Day 27 Year 1966 | | | | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 1, 1873 | | 9. AGE (In years last birthday) 92 yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Months | Days | Hours | Min. |
| IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| Months | Days | | | | | | | | | | | | | | |
| Hours | Min. | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman | | | | 10b. KIND OF BUSINESS OR INDUSTRY Seafood | | 11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Joseph E. Wingate | | | | | 14. MOTHER'S MAIDEN NAME Laura Fallin | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Mrs. Walter S. Wingate, RFD3, Cambridge, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition DUE TO 2042 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Leukemia, chr. monocytic DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mos 6 mo | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from..... Dec 1965 , to..... Feb 27, 1966 , that (I) (we) last saw the deceased alive on..... Feb 25, 1966 , and that death occurred at..... 4 PM , from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) James U. Thompson, MD | | | | | 22d. ADDRESS Locust St., Cambridge, Maryland | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF Mar 1, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park | | 23d. LOCATION (City, town or county) (State) Cambridge, Maryland | | | | | | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS LeCompte Funeral Service, Cambridge, Maryland | | | | | 25a. REC'D BY REGISTRAR DATE MAR 1 1966 | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(continued)

7. 4. 2008

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1992-1993
